ALLERGY QUESTIONAIRE

List your complaints and when they started. _____

_____

What foods do you crave or eat often?
_____

Do any foods make you sick or disagree with you? _____Any you dislike? _____

- ❑ Yes No Do you wake up between 1:00am and 5:00 am with headache, dizziness, stomach cramps or bloating?

Any family history of hay fever, asthma, emphysema, hives, eczema or other chronic skin condition, migraine, dizziness, stomach cramps, bloating, dry cough, colitis, thyroid problems, food allergies or sinus condition? _____

- ❑ Yes No During childhood did you have eczema, hay fever, asthma, frequent earaches, or colic?
- ❑ Yes No Do you have itching of your skin or palate? Skin rash? Yes No
- ❑ Yes No Do you notice swelling of feet, ankles, hands, or face on arising in the AM?
- ❑ Yes No After a full meal in the middle of the day, do you ever experience fatigue 2-3 hours later?
- ❑ Yes No Do you eat snacks frequently between meals?
- ❑ Yes No Do you have alternating constipation and diarrhea?
- ❑ Yes No Do you have joint or muscle pain or stiffness:
- ❑ Yes No Do you experience excessive chilling when a sudden change in temperature occurs?
- ❑ Yes No Do you have sinus headaches?
- ❑ Yes No Do you have headaches in the back of your head?
- ❑ Yes No Do you experience gas, bloating, belching, abdominal distention or cramps after meals?
- ❑ Yes No Do you ever have numbness of face, arms or legs at periodic interval with no apparent cause?
- ❑ Yes No Do you experience drowsiness, headache, or bloating after ingestion of a cocktail, beer or wine?
- ❑ Yes No Are you allergic to penicillin?
- ❑ Yes No Do you have diarrhea, even mild or intermittently?
- ❑ Yes No Do you have repeated symptoms on awakening such as headache? Can you make it go away by eating or drinking any particular food? Yes No
- ❑ Yes No Do you have any obvious reaction to a particular food?
- ❑ Yes No Do you clear your throat frequently?
- ❑ Yes No Do you have any dizziness or ringing in your ears?
- ❑ Yes No Do you experience weight fluctuations?

- ❑ Yes No Do you ever have itching of your midback or halitosis?
- ❑ Yes No Do you experience fluctuations in your vision?
- ❑ Yes No Do you have recurring fungal infections?
- ❑ Yes No Do you experience itching of your eyes?
- ❑ Yes No Do you have a dry cough? Is it intermittent or constant? Daytime or nighttime?
- ❑ Yes No Do you have frequent colds?
- ❑ Yes No Do you sneeze excessively? Is it seasonal or year round?
- ❑ Yes No Do you have any nasal drainage or blockage? Loss of smell or taste?

  Are your symptoms worse at home or at work? _____
- ❑ Yes No Are you exposed to any animals?

How old is your home? ____ yrs. old / Workplace?_____ yrs. old.

Is there any particular room or location where symptoms worsen? _____

What is your occupation?_____

What type of hobbies or sports do you participate in?_____

What type of heating and air conditioning do you have at home? _____ At work? _____

Is the air too dry or too damp? Do you use a humidifier or air purifier?

List anything at home or at work that you think you may be allergic to._____

Are your symptoms worse indoors or outdoors? _____ Morning or night? _____

- ❑ Yes No Do you use any pillows or comforters filled with down or feathers?
- ❑ Yes No Does your nose stop up when you go to bed?
- ❑ Yes No Do you ever retaste food eaten earlier?
- ❑ Yes No Do you have burning when urinating or have frequent urges to urinate?
- ❑ Yes No Do you have frequent urinary tract infections?
- ❑ Yes No Do you have a basement?